ONE SOURCE MEDICAL SOLUTIONS, INC.

ONE COMPANY. MULTIPLE SOLUTIONS.™

MEDICAL NECESSITY FOR LYMPHEDEMA PUMP AND GARMENT

CLIENT'S NAME: _____ MEDICARE ID: _____

DATE OF BIRTH: __/__/____ HEIGHT: _____ WEIGHT: _____

ADDRESS: _____

TELEPHONE: (____) ____-_____

PHYSICIAN OR TREATING PRACTITIONER NAME: _____

EXAMINATION DATE: _____

PLEASE LIST IN DETAIL THE ETIOLOGY OF YOUR PATIENT'S EDEMA, ANY MEASUREMENTS PRIOR TO TREATMENT, WHAT OTHER TREATMENTS HAVE BEEN TRIED AND FAILED, AND CLINICAL RESPONSE OF INITIAL TREATMENT ALONG WITH SUPPORTING DIAGNOSIS:

_____

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TYPE OF ACCESSORIES REQUIRED:

Circle One: Arm Garment 31" Half Leg Garment 20" Full Leg Garment 26"

EXPECTED LENGTH OF TIME PATIENT WILL REQUIRE PUMP:

Months Needed _____ (99 = Lifetime)

PHYSICIAN: _____

ADDRESS: _____ **CITY:** _____

STATE: ____ **ZIP:** _____ **PHONE** (___) ____-_____ **FAX** (___) ____-_____

PHYSICIAN OR TREATING PRACTITIONER'S SIGNATURE: _____

DATE SIGNED: _____ UPIN: _____ NPI: _____

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